HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

Office Use
MRN:

CONSENT TO ACCESS / DISCLOSE / TRANSMIT / EXAMINE PERSONAL HEALTH INFORMATION

I hereby authorize Hôtel-Dieu Grace Healthcare to disclose the requested health information to the recipient indicated for the purposes listed:

Patient/Client's **Last** Name (Print) _____ Patient/Client's **First** Name (Print) _____ Middle Initial(s) _____

☐ Can we leave you a voice message?

Date of Birth (i.e: July 1, 1950) _____ Telephone Number _____

Mailing Address (including City, Province, Postal Code) _____

Email Address _____

To: _____ for purpose of:
(Name of Person / Agency requesting information)

☐ Personal Use ☐ Legal /Lawyer ☐ Insurance

☐ Other (please specify) _____

I wish to obtain/disclose the following record(s):

Please specify report(s): _____

For the specific visit: _____ **or** Visit(s) from: _____ to _____
(Enter date i.e: July 1, 1950) (Enter dates i.e: July 1, 1950)

NOTE: In accordance with PHIPA (Personal Health Information Protection Act) authorization must be signed by the patient/client and **if incapable by the Parent/Guardian or Substitute Decision Maker/Executor**. A substitute decision maker is a person authorized by PHIPA to consent on behalf of an individual, to disclose personal health information about the individual.

Only complete this section if you are the Parent/Guardian/Substitute Decision-Maker/Executor, please provide your contact information: (Copies of documentation that provide your authority as a Substitute Decision-Maker must be provided)

☐ Copy of Will ☐ Power of Attorney Documents ☐ Notarized Letter ☐ Parent/Guardian

Last Name (Print) _____ First Name (Print) _____ Middle Initial(s) _____

Date of Birth (i.e: July 1, 1950) _____ Relationship to Patient/Client _____ Telephone Number _____

If different than above mailing address (including City, Province, Postal Code) _____

$30.00 non-refundable search fee is required to complete this request.

Signature: _____ **Date:** (i.e: July 1, 1950) _____
Patient/Client/(Child if applicable)/Parent/Guardian/Substitute Decision-Maker/Executor

This Consent for Disclosure is valid for 12 months. It pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn at any time by written notification to the Health Information Management Department. Withdrawal of consent is not retroactive to information already disclosed.

4005HD

HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

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CONSENT TO ACCESS / DISCLOSE PERSONAL HEALTH INFORMATION

Office Use Only

Verification of identity of individual consenting to the disclosure:

Form of ID: ☐ Driver's License ☐ Passport ☐ Notarized letter/Lawyer's letter ☐ Birth Certificate
☐ Other (specify): _____

ID Checked by:

_____ _____
Print Name Signature

Person Identified/Authorized for Pick-Up:

_____ _____
Print Name Relationship to Individual Consenting

_____
Telephone Number

Invoice Issued: ☐ N/A _____ _____
Date (MM/DD/YYYY) Signature

Amount Owing: $_____

_____ _____
Signature of Person Authorized for Pick-Up Date (MM/DD/YYYY)

Form of ID: ☐ Driver's License ☐ Passport ☐ Notarized letter/Lawyer's letter
☐ Other (specify): _____

ID Checked by:

_____ _____
Print Name Signature